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TO DETERMINE THE MOST EFFECTIVE COMMITTEE SYSTEM AT US DARNALL ARMY HOSPITAL FORT HOOD, TEXAS

A Problem Solving Project

Submitted to the Faculty of

Baylor University

in Partial Fulfillment of the

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of

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by

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This paper identified an overall problem with committee meetings and the negative results of ineffective management. It explored methods for system improvement and alternatives within the health care facility. Keywords: Military medicine Management Planning and control, Hospital administration, Operations research, Efficiency theses. (AW)

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The Problem

Conditions prompting the study

The committee system at U.S. Darnall Army Hospital received the following finding during the hospital's Annual General Inspection (AGI) on October 2-6, 1978:

> A review of the MEDDAC directive...which established committees, boards, conferences, and councils required extensive revision. This plus a review of committee minutes revealed a need to thoroughly address the entire committee structure. The problems were of such a large magnitude that only a portion of the deficiencies will be addressed...[1]

Additionally, the Executive Officer observed that several aspects of committee management were negatively affecting the committee system: too many committees (thirty), overlapping responsibilities and duplicated membership, lack of formal agendas, little advance preparation, and significant absenteeism. Meetings themselves appeared to be poorly organized and controlled by the chairman. Followup on committee decisions was often haphazard. In short, it appeared that the committee system was not functioning as an effective management tool.

Statement of the problem

The problem was to determine the most effective method or

combination of methods for improving the committee system at U.S. Darnall Army Hospital.

Limitations

Regulations.--The Army Medical Department, as a governmental activity, receives detailed guidance on all matters, to include the functioning and organization of the hospital committee system. Additionally, the Joint Commission on Accreditation of Hospitals establishes certain guidelines for committees that must be met in order for a hospital to achieve an accredited status. Thus latitude in structuring the committee system is significantly reduced.

Staff attitudes.--A hospital is a very complex organization, made up of very capable, highly specialized people. It is through the committee system that many of these people achieve personal and group recognition, influence top management and other parts of the organization, and effect change. Any change to the current committee system may be seen as a threat to some, and therefore may be resisted. Any changes to the system will require close coordination with the staff, and must have the support of top management.

Review of Applicable Literature

General

Reasons for having committees--Koontz and O'Donnell,[2] and Decker and Johnson,[3] among others, see the following as legitimate reasons for using committees. Use when...

--there is a concern of investing too much authority in one individual.

--there are many interested groups with a desire to be included in policy making.

--there is a need to coordinate/integrate plans and policies.

--total authority must be consolidated in order to accomplish a task or program.

--motivation can be achieved through participation.

--avoidance of immediate action is desired.

--it is felt that group deliberation and judgment will produce a more thorough and effective result

--the combined knowledge of several different specialties is required to initiate a course of action.

The case against committees.[4]--Committees have the following disadvantages:

--they are costly in terms of time and dollars.

--they tend to produce watered-down decisions.

--there is a tendency for one member (usually the chairman) to dominate.

--individual responsibility for decisions is reduced.

--a strong, obstinate minority can dominate and have potentially undesirable influence over decisions.

Ingredients for a successful committee.[5]--Insure that:

--there is a well-defined authority and scope of activity.

--committees are combined when authority overlaps with another.

--size is minimized by including only those members whose expertise is absolutely required.

--members come from the same level within the organization and possess requisite authority and knowledge.

--agendas are circulated well in advance of meetings to allow for advance thinking and sharp presentation of proposals.

--committees ordinarily do not have "line authority" (control of actual organizational operation), but rather "staff authority" (decide on jurisdictional matters, formulate policy and conduct long range planning).

--the chairman is picked not only for subject expertise, but for ability to manage a committee. The selection of chairmen is probably the most critical issue in committee formation, for the chairman can reduce the committee's effectiveness or increase it by insistence on good, advance, administrative planning, integration of deliberation, and firm control of discussion.

--committee minutes accurately reflect decisions made, attendance, and set responsibility for accomplishment of pending actions, to include time deadlines.

Committee size.--Many authors[6] suggest that membership should be limited generally to between three and nine, with five members being ideal. Filley[7] cites several scientific studies that measure socio-emotional relations among group members as indicators of group effectiveness. These studies show that in groups larger than approximately seven, (1) members have trouble keeping track of other

members as individuals, and (2) reluctant contributors tend to "drop out" allowing the group to become dominated by the most active individuals. In like manner, Filley notes[8] groups of three or four members are dysfunctional, in that they tend to be too tense, passive, tactful, and constrained to work in a satisfying manner. He sees five members as the ideal as far as emotional interaction is concerned, although he recognizes that where a varied range of knowledge and expertise is needed, larger groups may be necessary.

Membership requisites.--Filley[9] analyzes membership behaviorally and notes that (1) committees in which there is a spirit of cooperation are more effective than those in which there is a sense of competition, and (2) that increasing heterogeneity of membership increases group problem solving potential and eliminates errors while generating more alternatives. Decker and Johnson,[10] page 36, advised that only inclined, knowledgeable, capable people who have a stake in committee outcomes should be included in membership. As noted earlier, Koontz and O'Donnell[11] stress membership from the same level of the organization with requisite knowledge and authority and avoidance of dominant personalities.

Most authors are in agreement that the chairman must be an individual who (1) understands group process, (2) understands the problems/issues/agenda at hand, (3) has the acceptance and confidence of the group, and (4) has the skill to resist needless debate. Filley[12] cites studies that show decision-making groups prefer directive

influence by the chairman. Benne and Sheets[13] cite two leadership roles in small groups: (1) the task role and (2) the group building and maintenance role. Ideally, both roles would be performed by the chairman, but if a choice must be made, the leader who fulfills the task role should be made chairman.

As noted earlier, Koontz and O'Donnell[14] are quite emphatic about the criticality of the chairman's role. Jay[15] provides many practical points on "chairmanship" that make for more effective meetings: (1) demand punctuality, (2) consider the psychology of seating arrangements, (3) control the garrulous, (4) draw out the silent, (5) protect the weak, (6) encourage the clash of ideas (not people), (7) avoid the suggestion-squashing reflex (on the part of the chairman), and (8) call on the most senior to speak last (otherwise they stifle/inhibit discussion).

Hospital committee structures

System models.--Grozuczak and Olander[16] relate the experience of a hospital that reduced its committees from sixteen to four (Executive, Medical Education, Medical Care Appraisal, and Service). The many areas of concern within each committee are divided among member physicians who "...oversee the permanent operation and organization of their assigned areas and deal with problems as they arise."[17]

In like manner, Jack[18] groups medical staff functions into three councils (Patient Care, Continuing Medical Education, Care Evaluation), with doctors assigned responsibility for the subfunctions within each council.

YaDeau[19] relates that in a hospital where he was Chief of Staff, the number of medical staff committees was reduced from twenty-two to eight. This reorganization was quite different from that described by Grozuczak and Jack. First, there were the fairly traditional committees -- Executive, Outpatient and Disaster, Education, Hospital Liaison, and Joint Conference -- but a "Professional Activity Committee" was established for each clinical service (medicine, surgery, and obstetrics/gynecology). The latter committees are essentially audit-oriented.

The trend toward heterogeneity in committee membership.--Traditionally, administrative staff members have been given limited representation in the medical staff committee system -- normally in the role of non-voting recording secretaries.[20] However, there has been a growing realization[21] that the medical staff must begin including non-physicians whose impact on the quality of patient care is substantial to their membership. The Joint Commission[22] has recognized this by requiring that responsibility for infection control be vested in a joint committee. Lindberg[23] takes this concept one step further by proposing that committees with joint (medical, administrative, ancillary, etc.) function and membership should report to a joint executive committee. Shortell[24] notes that certificates of need review, prospective reimbursement, and development of larger systems of delivering care all mean there will no longer be such a thing (if there ever has been) as a purely clinical or purely administrative decision.

The matrix organization and hospital committees.--Several authors see the matrix organization as a model for future organization of hospitals in order to meet the complex problems generated in a rapidly changing environment. Tippett[25] sees the matrix organization as made up of a series of "ad hoc, temporary, single-problem-oriented special task force(s) that in varying degrees (are) separated from the parent organization." The task force is made up of members of the parent organization who have expertise and knowledge to bring to bear on the problem.

Moore and Lorimer[26] see the matrix organization as formed either for completion of specific projects or permanent operations, but in either case, the matrix is composed of people throughout the organization who are chosen for their expertise. In the hospital setting, Moore and Lorimer see the matrix organization as controlling specific permanent operations, such as whole patient care floors or special care units.

Shortell[27] believes that the medical staffs of the future will be organized along matrix lines, with individual physicians being members of both traditional clinical departments and functional hospital units.

Neuhauser defines[28] the matrix organization as "The existence of both hierarchal (vertical) coordination through departmentalization and the formal chain of command, and simultaneously lateral (horizontal) coordination across departments..."

What is not found in the literature is the seemingly obvious fact that the committee systems of the future, made up of heterogeneous groups of doctors, nurses, technicians, and administrators will be essentially matrix organizations. Presently, it is merely a matter of authority, rather than organization, that would limit some hospital committee systems from being considered matrix organizations.

Committee requirements in U.S. Army hospitals

Headquarters, U.S. Army Health Services Command (HSC), the operational headquarters for all Army hospitals in the United States, Puerto Rico, and Panama, has published a pamphlet[29] that contains the majority of committees, boards, councils, and conferences required by that organization of its subordinate hospitals. A complete listing of these and all committee requirements is found at Appendix B. Generally, this pamphlet reflects JCAH requirements, the main exception being that JCAH requires[30] a multidisciplinary committee for multipurpose special care units.

There are three additional committees required by other military regulations: (1) Energy Conservation (required by HSC Regulation 11-3),[31] (2) Linen Management (HSC Regulation 40-15),[32] and (3) Equal Employment Opportunity (Army Regulation 600-21).[33]

In all there are some twenty-five specific functions required to be carried out by committee.

Procedure for Problem Resolvement

Analysis of current committee system

Describe the existing system.--What committees does the hospital presently have? How is the system administered? What data can be gathered to quantify the analysis of the existing system? How does the system compare to other systems of the same type?

Analyze the problems or needs of the existing system.--Essentially this will consist of comparing the current system with system models described in the literature, comparison with other systems at other hospitals, and delineation of insight gained by the researcher through the process of observation.

Criteria for evaluation of alternatives.--The premise is that the current system can be salvaged, and that no changes should be made to it unless specific, measurable benefits can be derived from such changes.

Design of an improved committee system

Define alternatives to present system.--Problem areas are met with specific alternatives. Additionally, alternatives to improve the system may be explored even when no specific problem exists.

Feasibility of alternatives.--Alternative courses of action are weighed against evaluation criteria.

The optimal feasible system.--Based on the evaluation of alternatives, the current system is revised in order to produce the most effective system allowing for system constraints.

Implementing the improved committee system

What must be accomplished?--Procedures for implementing the new committee system are defined.

Performance evaluation standards.--Quantifiable criteria are developed for comparing the new system with the old.

Recommendations

A statement of the specific actions that the hospital should take in order to implement the new committee system.

FOOTNOTES

[1]Academy of Health Sciences, U.S. Army, Annual General Inspection, FY 1979, U.S. Army Medical Department Activity, Fort Hood, Texas (Fort Sam Houston, Texas: November 1978), Finding E-1.

[2]Harold Koontz and Cyril O'Donnell, Principles of Management 4th Edition (New York: McGraw-Hill Book Company, 1968), pp. 377-387.

[3]C. Richard Decker and Ross H. Johnson, "How to Make Committees More Effective," Management Review (February, 1976), 34-40.

[4]Koontz and O'Donnell, loc cit; Decker and Johnson, oc cit.

[5]Koontz and O'Donnell, p. 388.

[6]Decker and Johnson, p. 37; Angelos A. Tsaklanganos, "Making Better Use of Committees," Management Review (June, 1975), 51.

[7]A.C. Filley, "Committee Management: Guidelines from Social Science Research," California Management Review (Fall, 1970), 19-20.

[8]Ibid., 15.

[9]Ibid., 16.

[10]Decker and Johnson, 36.

[11]Koontz and O'Donnell, p. 387.

[12]Filley, 17.

[13]K.D. Benne and P. Sheats, "Functional Roles of Group Members," Journal of Social Issues 4 (Spring, 1948), 41-49.

[14]Koontz and O'Donnell, p. 402-403.

[15]Antony Jay, "How to Run a Meeting," Harvard Business Review (March-April, 1976), 43-57.

[16]JoAnn Grozuczak and George A. Olander, "A Problem-Oriented Approach to Medical Staff Committee Structure," Hospital Medical Staff 3 (November, 1974), 10-15.

[17]Ibid., 13.

[18] William W. Jack, "Medical Staff Functions and Leadership," Hospital Progress (November, 1970), 76-79.

[19]Richard E. YaDeau, "We Cut the Hell Out of Time Wasting Hospital Work," Medical Economics (March 29, 1971), 106-112.

[20]J.E. Crank, "Administrators Can Help Staff Committees," Modern Hospitals (December, 1974), 102.

[21]Grozuczak, 12.

[22]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 1979 Ed. (Chicago: JCAH, 1978), p. 65.

[23]Curt Lindberg, Realign Committees that Perform Medical Staff-Hospital Functions," Hospitals (August 1, 1976), 89.

[24]Stephen M. Shortell, "Managerial Models," Hospital Progress (October, 1977), 66.

[25]Gordon L. Lippett, "Hospital Organization in the Post-Industrial Society," Hospital Progress (June, 1973), 58.

[26]Terence F. Moore and Bernard E. Lorimer, "The Matrix Organization in Business and Health Care Institutions: A Comparison," Hospital and Health Services Administration (Fal, 1976), 19.

[27]Shortell, 66.

[28]Duncan Neuhauser, "The Hospital as a Matrix Organization," Hospital and Health Services Administration (Fall, 1972), 19.

[29]Headquarters, U.S. Army Health Services Command, HSC Pamphlet Number 40-1, Committees, Boards, and Functions (Ft Sam Houston, Texas: January, 1979), p. 21.

[30]Joint Commission, p. 174.

[31]Headquarters, U.S. Army Health Services Command, Regulation 11-3, Energy Conservation (Ft Sam Houston, Texas: November 18, 1972), p. 3.

[32]Headquarters, U.S. Army Health Services Command, Regulation 40-15, Hospital Linen Management (Ft Sam Houston, Texas: October 26, 1976), p. 2.

[33]Headquarters, Department of the Army, Regulation 600-21, Equal Opportunity Program in the Army (Washington, D.C.: TAGO, June 20, 1977), p. 2-1.

II. DISCUSSION

Current System Analysis

Description

General.--The current system is described in Fort Hood Medical Department Activity (MEDDAC) Memorandum 40-20, Establishment of Committees, Boards, Conferences, and Councils, dated November 10, 1977. Table 1 is a matrix diagram showing the current committees, boards, conferences, and councils (hereafter referred to simply as "committees," since the Army apparently makes no distinction between these entities) and principal membership. Note the membership category referred to as "OTHER." These are personnel who are (1) not members of the hospital staff, or (2) are not a branch/service/division/department chief, who have membership on no more than one committee. This allows Table 1 to be manageable and concentrate attention on principal staff members only. Memo 40-20 identifies membership by duty position, rather than by name, in order to stress the skills and knowledges required by the committee. Each committee has a chairman and a recorder. Formal minutes are prepared according to an established format, signed by the recorder and chairman, and forwarded to the commander for approval. Those committees dealing with patient care are reviewed by the Executive Committee, which is

TABLE 1

COMMITTEE ASSIGNMENTS

	Accredit	APC	Blood	CmtyHEd	Construc	ChildPro	CrJntIs	Disaster	Education	EMS	EMEJAdsy	Energy	EqualOp	Exective	HConsumr	Infectn	JntStaff	JrEnlstd	Library	Linen	MCEC	MilAwards	MnrConstr	NrsAudit	PBAC	JrPBAC	Rabies	RapeCris	Safety	TAB	TOTAL	
Commander														X	X		X														5	
Chief, Professional Svcs	X	X			X		X	X	X		X			X			X		X		X				X	X				X	14	
Executive Officer	X	X			X			X	X					X		X	X		X	X	X	X	X		X			X			15	
Commander, DENTAC															X		X														2	
Executive Officer, DENTAC																	X												X		2	
Chief, VETAC				X								O					X						X		X		X				5	(6)
Chief, Dept Medicine	X	X					X	X	X	O						X	X		X		X				X	X	X			X	13	(14)
Dept Med Admin Assistant																															0	
Chief, Pediatrics						X																				X	X			X	4	
Chief, Dept Surgery	X	X	X		X		X	X	X	O						X	X		X		X				X	X	X			X	15	(16)
Dept Surg Admin Assistant																															0	
Chief, OB/GYN			X													X													X	5	
Chief, General Surgery								X																	X				X	3	
Chief, Physical Therapy	X							X																	X					3	
Chief, Orthopedics			X																											1	
Chief, EENT			X																											2	
Chief, Dept Nursing	X	X			X			X	X	O	X	O			X		X	X		X	X	X	O	X		X	X			X	17	(20)
Infection Control Nurse																	X							X							2	
Nursing Education				X							X													X							3	
Chief, Dept Radiology	X									O							X								X	X				4	(5)
Chief, Dept Psychiatry							X			X							X		X		X					X		X		X	8	
Chief, Social Work						X			X												X					X		X			5	
Chief Pharmacist	X																X		X		X				X	X				X	7	
Chief, Dept Primary Care	X	X					X	X		X							X	X			X				X	X	X			X	14	
Primary Care Admin Assist																															0	
Chief, Emergency Medicine		X						X	X	X																					4	
Head Nurse, ER		X																										X			2	
Chief, Family Practice																															0	
Chief, Dept Pathology	X	X	X							O							X				X				X	X				7	(8)
Blood Bank Manager			X																												1	
Chief, Oral Surgery		X	X					X								X			X										X	6	
Chief, Clinical Spt Div		X		X				X	X			O		X			X		X			X	X		X			X			11	(12)
Patient Representative				X											X																2	
Librarian																			X												1	
Chief, Central Appointment																															0	
Chaplain				X									X				X														3	
Chief, Preventive Medicine	X	X						X				O				X	X								X		X		X		8	(9)
Entomologist																X													X		2	
Environmental Health Off					X											X													X		3	
Community Health Nurse				X		X																									2	
Adjutant		X		X													X														3	
Chief, Personnel	X							X			X		X				X				X				X						7	
Commander, Med Company								X			X	X					X														4	
Comptroller	X	X															X					X	X		X						6	
Chief, Logistics	X	X			X			X				X				X	X			X			X		X				X	X	12	
Chief, Service Branch																				X			X						X		3	
Chief, Plans and Training	X							X	X	O							X														4	(5)
Chief, Food Service	X			X				X	X			O				X	X		X			X			X				X		11	(11)
Command Sergeant Major												X					X					X								X	4	
Orgnl Effectiveness Off																	X														1	
Chief, Patient Admin	X	X						X									X				X				X						6	
All Others				2	1	8		1		1	2		11		11	5	3	10		1		2		6		4	1	5	2		74	
TOTAL	17	16	7	10	7	11	5	17	13	10	7	8	14	14	14	17	29	10	11	5	11	9	7	8	17	18	7	8	13	12		

NOTE: An "X" = the activity chief; an "O" = an activity representative

heterogeneous, i.e., multidisciplined (physician, chief nurse, and administrator). The majority of committees reflect such heterogeneity. There is no formal agenda used in most committee meetings, but the minutes contain an "actions pending" section that serves as an agenda at the subsequent meeting. The chiefs of Professional Services and Department of Surgery chair most of the clinically-oriented committees, and the Executive Officer (administrator) chairs the majority of the non-clinically-oriented committees. Memo 40-20 reflects, for each committee, (1) this positional membership, (2) a brief description of committee functions, (3) a statement of meeting frequency, (4) references that authorize/require the committee, plus (5) administrative details on minutes preparation. A quorum is defined in the memo as a simple majority of committee membership.

TABLE 2

DESCRIPTIVE STATISTICS

Number of committees	30
Average membership	11.4
Standard deviation	5.1
Membership range	25
Midpoint of range	10-11
A sample of committee meetings	23
Average meeting length (minutes)	55.56
Standard deviation	21.24
Range of meeting length (minutes)	70
Midpoint of range	55
Average delay in starting time (minutes)	5.78
Standard deviation	5.15
Starting time delay range (minutes)	15
Midpoint of range	5

TABLE 2--Continued

Average percent meeting attendance	85.65%
Standard deviation	13.64%
Percentage attendance range	37.5%
Midpoint of range	88.89% and 90%

Membership responsibilities of the top nineteen most "committeed" staff members

Average number of committees per member	9.84
Standard deviation	3.81
Range of committee responsibilities	12
Midpoint of range	10

TABLE 3

COMMITTEE RESPONSIBILITIES BY POSITION
(OVER FIVE COMMITTEES)

Position	Committees
Chief Nurse	17
Executive Officer	15
Chief, Department of Surgery	15
Chief, Professional Services	14
Chief, Department of Medicine	13
Chief, Logistics Division	12
C, Department of Primary Care	12
Chief, Clinical Support Division	11
Chief, Food Service Division	10
Chief, Preventive Medicine Activiey	8
Chief, Deparement of Psychiatry	8
Chief, Personnel Division	7
Chief, Department of Pathology	7
Chief, Pharmacy Service	7
Chief, Comptroller Division	6
Chief, Oral Surgical Service	6
Chief, Patient Administration Div	6
Chief, Social Work Service	5
Deputy for Veterinary Activity	5

Survey results.--A questionnaire (Appendix C) was prepared and distributed at the committee meetings described in Table 2. Results are as follows:

--Of those responding, 49 percent (a total of eighty-two members) said that no one had ever briefed them on their committee responsibilities, although 65 percent said that they had read that portion of Memo 40-20 dealing with the committee in question. Additionally, 88 percent felt that they understood the purposes and objectives of their committees. This expressed confidence may be open to question since 69 percent felt that a briefing on their committees' goals, objectives, and purposes would be useful.

--The minutes of the committees, which are supposed to serve the dual purpose of (1) informing the member of meeting results, and (2) serving as an agenda for the next meeting, were "usually" read by 80 percent of the members. However, only 32 percent said that they were well prepared to participate in meeting activities at the time of the meeting.

--It was felt by 20 percent that committee chairmen did not do a good job of running their committees. Only 9 percent felt that the committee system at Darnall Hospital was generally worse than those systems of other Army hospitals.

--A total of 52 percent felt that their committee had a lot of authority, but only 37 percent felt that the committee provided valuable guidance in their areas of work interest. However, 86 percent felt that committees had the potential of being valuable management tools at Darnall Army Hospital.

--It was the opinion of 83 percent that the number of people on their committees was about right; 75 percent felt that meeting lengthy was about right.

--Finally, committee members were asked to state in their own words the reason for having committees at Darnall Army Hospital. Results are shown in Table 4. (Percentages indicate the proportion of total responses, rather than respondees.)

TABLE 4

REASONS FOR HAVING COMMITTEES

Response	Percentage
To meet JCAH, other requirements	25
Provide more effective management	22
Improve communication/coordination	14
Insure quality patient care	13
Assist the commander	10

Comparable systems.--The committee systems of Silas B. Hayes (Fort Ord),[1] Womack (Fort Bragg),[2] and Moncrief (Fort Jackson)[3] Army Hospitals were evaluated to determine if any significant differences existed in other Army hospital committee systems.

--The Silas B. Hayes Army Hospital committee system essentially parallels the Darnall Hospital system. Hayes appears to have kept individual committee membership smaller (although there are eight additional committees), and there are fewer administrative personnel on clinically-oriented committees. A committee hierarchy diagram is published (which Darnall does not have) which shows the relationship (approval and/or review) of committee activity. Published agendas appear to be optional. Committee minutes fail to reflect pending action (which Darnall Army Hospital does do). Major committee structure differences are: (1) Hayes has two junior (administrative and

professional) program budget advisory committees (PBAC), while Darnall has one (the administrative portion is combined with the senior PBAC), and (2) there are two executive committees at Hayes - hospital and MEDDAC. The former reviews all patient care-oriented committees. There is no master schedule for meeting dates and times.

--At Moncrief Army Hospital there are nine more committees than at Darnall, but membership on each committee appears to be smaller. Committee minutes do not indicate pending actions and agendas are only encouraged. The executive committee reviews the minutes of all committees - which is the only hierarchy demonstrated in the committee system. The committees themselves are basically structured as at Darnall. There is no master schedule for meeting dates and times.

--Womack Army Hospital has four more committees than does Darnall. There is a hierarchy of committees established, through which the executive committee reviews minutes of all clinically-oriented committees, while all other committee minutes go directly to the commander for his approval. The minutes do not reflect pending actions and agendas are recognized "where applicable." All committee meetings are on a master schedule (which Darnall does not have) for dates and times. Committee membership appears larger than that at Darnall, with many non-clinical personnel sitting as full members of patient care committees.

<u>System problems and shortcomings</u>

Coverage of requirements.--All JCAH and Army committee requirements appear to be met except (1) the required special care committee[4] mentioned during the introductory chapter, and (2) requirements for utilization review.[5] Although many committees must remain as separate, distinct entities, either because (1) military regulations so require,[6] and/or (2) because of workload; there are several committees that might be combined. Table 5 lists such committees potentially qualifying for combination, either because (1) they are required only by Fort Hood MEDDAC, (2) no regulation specifically requires separate establishment, or (3) workload appears to favor union with other committees.

TABLE 5

COMMITTEES THAT MIGHT BE COMBINED

Moderate workload and no requirement for separate establishment

Community Health Education Committee
Energy Conservation Committee
Linen Management Committee
Special Care Units Committee

Committees Required only by MEDDAC

Disaster Committee
Minor Construction Review Board
Enlisted Education Advisory Board
Junior Enlisted Advisory
Rape Crisis Council
Junior Program Budget Advisory Committee
Hospital Construction Committee

Committee management.--The following issues were noted:

--of the twenty-three committee meetings specifically observed, only three had prepared formal agendas. This appeared to result in

specific weaknesses in the meeting process of several of the committees: (1) membership was frequently unprepared to discuss issues or to present reports, (2) the chairman frequently did not know the agenda at the start of the meeting, (3) discussion topics were often not effectively considered or dealt with, causing the meeting to take an inordinate amount of time, (4) the recorder had difficulty deciding what to record, and (5) topics required by JCAH or military regulation failed to be included as items of new business.

--Several chairmen appeared to lack the skills required for the conduct of effective, efficient meetings. For example, (1) chairmen were often late for their own meetings and/or tolerated tardiness in others, (2) few chairmen involved all members in committee discussions - either by being too autocratic or to laissez-faire, (3) time (discussion) was improperly managed in that the membership could too easily digress from the topic at hand, and/or the chairman failed to summarize and press for decisions, (4) many chairmen often failed to pinpoint member responsibility and set suspense dates for accomplishment of committee actions, (5) insufficient prior coordination often appeared to be the case in the presentation of reports to the committee, and (6) chairmen often appeared unprepared to conduct meetings.

Committee membership.--As noted earlier,[7] optimum committee size for member interaction is about five to seven. Membership at Darnall averages over eleven. Obviously the need for a specific

variety of knowledge and expertise might require a larger membership, especially in a hospital. But there are many instances in the Darnall committee system where membership appears to be extraneous to the primary mission of the committee. For example, the Chief of Logistics Division and the Executive Housekeeper sit as full voting members on the Infection Control Committee; the Medical Records Librarian is a full voting member on the Medical Care Evaluation Committee; and the Chief, Logistics Division sits as a full voting member of the Therapeutic Agents Board. Obviously, these personnel do have some relationship to the committee, but the danger is that committee size may grow and grow with additions to membership based on potential contribution to committee business. Observation indicates that such is the case, for several members of many committees appear to sit with no significant meeting involvement. There is no distinction made between working <u>for</u> the committee versus <u>sitting as a member</u>; providing expert advice to the committee on certain specific, limited issues versus sitting as a full voting member on all issues. Additionally, several department and division chiefs appear to sit on committees in order to supervise their subordinates, who are members. The fact that nineteen staff members sit on an average of ten or more committees reflects the present lack of membership criteria, is a probable waste of manpower, and probably has dysfunctional consequences to the committee process.

Inadequacies of the committee regulation.--MEDDAC Memorandum 40-20 does not address the following issues sufficiently.

--There is no real hierarchy of committees established, except that those related to patient care are reviewed by the Executive Committee. There are other committees that should be part of the review process. Medical Care Evaluation Committee should review all audit committees, and those reviewing the quality of care and utilization of resources. The Ambulatory Patient Care Committee should review the minutes of all committees dealing with outpatient care.

--Meeting scheduling conflicts. There is no central system for scheduling all meetings, nor are meeting dates and times standardized, resulting in conflicting demands on membership time. Some meetings are scheduled at the height of outpatient, surgical, and administrative workload periods, meaning that members must miss meetings or allow workload to accumulate.

--The memorandum does not define the authority of the committees to take or require action. Some committees are strictly involved in staff planning and review, while others perform specific on-going functions directly involved in hospital operations. Some committees have a greater need for specific authority if they are going to be effective management tools, and such authority should be defined.

--Many references are outdated.

--The functions and responsibilities of many committees are inadequately defined, leading to failure to fulfill JCAH and military requirements.

--There is no system defined for briefing new committee members.

Changing the Current System

Criteria for evaluation of alternatives

Meet regulatory requirements.--Not only should changes fill any regulatory gaps in the current committee system, but changes should not contradict requirements of accrediting bodies and higher headquarters.

Improve the meeting process.--Changes to the system should facilitate the efficiency and effectiveness of committee meeting procedures.

Improve productivity.--Any changes to the system should have a positive effect on workload productivity of the hospital staff. This would result if staff members have more time to devote to their routine clinical and administrative duties.

Reduce individual committee burden.--Although related to criteria previously mentioned, the essence of this criterion is to "spread the wealth" of membership, and as such, include more than mere reduction of actual committees or membership on an actual committee.

Manageability.--Any changes to the system should not increase the administrative effort required to manage the system.

Improvement of statistical data.--Actually this is related to evaluation of the performance of the new system, but the means and standard deviations tabulated in Table 2 should be reduced, which, in essence, would mean that overall committee workload per staff member would be reduced, and that workload differences between staff members would also be reduced.

Improve expectation.--As noted in the questionnaire survey results, staff members are not satisfied with their meeting preparedness, committee effectiveness, and their knowledge of committee goals and functions.

Meet constaint of staff acceptability.--A significant restraint noted earlier is that changes to the system must be acceptable to staff and management.

Techniques for alternative evaluation

Because the objective is to improve on the current system rather than to create a new one, changes must be considered on an individual basis or on their collective effect, rather than as a part of a distinct alternative system. The following techniques will be used.

System matrix.--Collectively, the proposed changes in membership and in the number of actual committees will be evaluated through comparison of the original committee system matrix (Table 1), with a

matrix including all proposed changes. Admittedly, this will provide a gross evaluation, but will give some idea of the overall effect of the changes.

Criteria matrix.--Alternatives to the present system will be compared to each other through analysis of their effect on the change criteria previously discussed. Admittedly, such evaluation will be by "the seat of the pants" in those instances where the effect of change cannot be quantified.

New System Design

Changes to the system

Number of committees.--Essentially, the alternatives are to add, eliminate, or combine committees as follows:

--Addition of committees. The only two committee functions required by regulation, but not fully implemented at Darnall Army Hospital, are Utilization Review and Special Care Units. There are two alternatives for adding these functions. Establish new committees or combine with others - for example, utilization review and/or special care could be combined with the Medical Care Evaluation Committee. Results of a comparison of these alternatives with the change criteria are shown in Table 6.

TABLE 6

ADDITION OF FUNCTIONS THROUGH
NEW OR COMBINED COMMITTEES

Criteria	Method	
	New	Combined
1. Meet regulatory requirements	Yes	Yes
2. Effect on meeting process	N/A	N/A
3. Effect on productivity	Negative	Positive
4. Effect on individual committee burden	Negative	Positive
5. Effect on committee manageability	Negative	Positive
6. Effect on statistical data	Negative	Negligible
7. Effect on acceptability	Acceptable	Unacceptable
8. Effect on staff expectations	N/A	N/A

At first glance it would appear that combining the functions with existing committees would be the most logical method because staff members would not be tied up with another committee and management would be easier. However, when the proposal was staffed with applicable staff members, it quickly became obvious that new committees were required for the following reasons. First, the only logical committee for combination, the Medical Care Evaluation Committee (MCEC), already suffers from an inordinate workload; second, the functions of the Special Care Units Committee deal with daily operation and policies, rather than evaluation and audit of care, which is the realm of the MCEC, and third, staff members who would most likely make up special care committee membership wanted a separate committee.

--Elimination of committees. Certain committees are not required by other agencies and lend themselves to consideration for elimination:

Hospital Construction (HC), Enlisted Education Advisory (EEA), Military and Civilian Awards Board (MCAB), and Dental Education (DE). A criteria comparison for eliminating these committees versus retention produces the matrix shown in Table 7.

TABLE 7

COMMITTEE ELIMINATION

	Committee			
Criteria	HC	EEA	DE	MCAB
1. Meet regulatory requirements	No	No	No	No
2. Effect on meeting process	N/A	N/A	N/A	N/A
3. Effect on productivity	Pos	Pos	Pos	Pos
4. Effect on individual committee burden	Pos	Pos	Pos	Pos
5. Effect on system management	Pos	Pos	Pos	Pos
6. Effect on statistical data	Pos	Pos	Pos	Pos
7. Effect on acceptability	Neg	Pos	Pos	Pos
8. Staff expectation	N/A	N/A	N/A	N/A

It appears that all Table 7 committees could be eliminated except Hospital Construction (HC). On April 3, 1979, the hospital broke ground for a four-year major construction project, and the principal staff elements feel that there needs to be a specific forum for coordination of construction details.

--Combination of committees. Probably the most difficult of tasks is that of combining committee functions that heretofore were separate - difficult primarily due to member reaction. The lengthening of some meetings by inclusion of tasks previously accomplished at other meetings is often seen as of greater significance than the elimination of some meetings altogether. Additionally, when committees are eliminated through combination with others, affected

staff members tend to look on such action as a threat to personal status. Table 8 is a listing of committees suitable for combination. These committees are not required under specific titles, although the functions are required to be addressed through committees.

TABLE 8

COMBINATION OF COMMITTEES

	Committees		
Criteria	Energy/Safety	APC/CHEC	Minor Cons/Linen
1. Regulatory requirement?	No	No	No
2. Meeting process effect	N/A	N/A	N/A
3. Productivity effect	Positive	Positive	Positive
4. Committee burden	Reduced	Reduced	Reduced
5. Manageability	N/A	N/A	N/A
6. Statistics effect	Positive	Positive	Positive
7. Staff acceptability	Negative	Neutral	Negative
8. Staff expectations	N/A	N/A	N/A

Initial staff reaction to combining Safety with Energy Conservation and Minor Construction with Linen Control was negative, while combining Ambulatory Patient Care with Community Health Education received no significant staff reaction. Most frequently expressed disagreement dealt with apparent dissimilarity of functions. However, in spite of initial staff disagreement, the combinations appear justified for the following reasons.

1. Energy Conservation and Safety Committee. The functions are similar in that they are both administrative and prevention-oriented. Safety Committee membership easily covers the membership of the current Energy Committee. In short, combination seems a rather painless

procedure when considering the benefits of not tying up personnel on two separate committees.

2. Minor Construction and Linen Control Committee. The Minor Construction Committee is not required by any agency outside of the hospital, although it serves a useful purpose (see Appendix D). Membership on both committees is almost identical. Again, the functions are similar (i.e., non-patient care, cost oriented). Neither committee is over burdened with work, and there would be a significant savings in administrative committee support and staff committee time.

Committee membership reduction.--Table 9 is the assignment matrix results after the proposed elimination/addition/combination of committees, and after membership reduction on individual committees. In review of committee membership requisites the following criteria were used. To qualify for specific committee membership, the staff member:

1. Must serve in an organizational position vital to the functioning of the committee.

2. Must possess a sufficient breadth and depth of knowledge so he would be considered qualified to vote on all matters appearing before the committee.

Another form of membership, the consultant, was initiated to cover those individuals who failed to meet both of the above criteria. The consultant would appear at committee meetings at the specific request of the chairman and have a vote only on those matters for which his expertise was required. In short, the consultant provides limited,

TABLE 9

PROPOSED COMMITTEE ASSIGNMENT

	APC	Blood	Construc	ChildPro	Cred.tls	Disaster	Education	EMS	EqualOp	Executive	Consumr	Infectn	IntStaff	InrEnlist	MEC	Library	MngrConst	OrsAudit	PBAC	PrPBAC	Rabies	RapeCris	Safety	SpecCare	TAB	UtilnRev	TOTAL	
Commander										X	X		X														3	
Chief, Professional Svcs	X		X		X	X	X			X			X		X	X			X	X					X	X	13	
Executive Officer			X			X	X			X		X	X		X				X				X			X	12	
Commander, DENTAC									O		X		X	O					X								5	(5)
Executive Officer, DENTAC													X				X						X				5	
Chief, Jet Activity									O				X	O			O		X		X						5	(5)
Chief, Dept Medicine	X				X		X					X	X	O	X	X				X	X				X	X	11	(12)
Dept Med Admin Assistant																								X			1	
Chief, Pediatrics				X																X	X						3	
Chief, Dept Surgery	X	X	X		X		X					X	X	O	X	X				X	X				X	X	13	(14)
Dept Surg Admin Assistant																								X			1	
Chief, OB/GYN		X																									1	
Chief, General Surgery							X													X				X			3	
Chief, Physical Therapy							X													X							2	
Chief, Orthopedics		X																									1	
Chief, EENT																				X							1	
Chief, Dept Nursing	O		X				X		X	X		X	X	O	X	X		X		X			O		X	X	15	(15)
Infection Control Nurse												X							X								2	
Nursing Education															X				X								2	
Chief, Dept Radiology													X	O						X							2	(3)
Chief, Dept Psychiatry				X	X								X	O	X	X				X		X			X		8	(9)
Chief, Social Work				X					O																		1	(2)
Chief Pharmacist													X							X					X		3	
Chief, Dept Primary Care	X				X								X	O	X					X	X				X		7	(8)
Primary Care Admin Assist								X																			1	
Chief, Emergency Medicine						X	X	X																			3	
Hea[illegible]																						X					2	
Chief, Family Practice	X																										2	
Chief, Dept Pathology		X										O	X	O	X					X							4	(6)
Blood Bank Manager		X																									1	
Chief, Oral Surgery		X					O					X				O					X						3	(5)
Chief, Clinical Spt Div	X						X		O				X			X		X		X			O				7	(9)
Patient Representative	X										X																2	
Librarian																X											1	
Chief, Central Appointment	X																										1	
Chaplain									O				X														1	(2)
Chief, Preventive Medicine			O									X	X	O					X		X						4	(6)
Entomologist																							X				1	
Environmental Health Off												X											X				2	
Community Health Nurse	X			X																							2	
Adjutant									O				X														1	(2)
Chief, Personnel Div									X				X														2	
Commander, Med Company													X														1	(1)
Comptroller													X				X		X	X							4	
Chief Logistics Div			X			X			O				X	O			X		X	X							6	(8)
Chief, Biomed Repair																							X				1	
Chief, Service Branch																	X						X				2	
Chief, Plans & Training						X							X														2	
Chief, Food Service Div	X						X						X	O					X				X				5	(6)
Command Sergeant Major													X														1	
Orgnl Effective Officer							X						X														2	
Chief Patient Admin Div									O				X	O	X											X	3	(5)
All Others			1	5		3		4	3		11			1				7		3	5	1	6				50	
TOTAL	11	6	7	9	5	8	13	7	13	4	14	9	28	14	10	8		8	9	10	15	7	2	10	9	7	6	

NOTE 1: An "X" = the activity chief; an "O" = an activity representative

NOTE 2: Totals indicate the number of committees on which the activity chief sits, numbers in parentheses are committees on which the activity is represented.

specialized knowledge that the committee has a requirement for on an irregular basis. Table 10 is a comparison of the proposed membership system with the present system.

TABLE 10

ESTABLISHMENT OF A CONSULTANT FORM OF MEMBERSHIP (PROPOSED)

	Current System	Add Consultant
1. Authorized by regulation?	Yes	Not addressed
2. Effect on meeting process	Reduces efficiency	More efficient
3. Productivity effect	Negative	Positive
4. Individual committee burden	Heavy	Lightened
5. Manageability	Hurts communication	Aids communication
6. Statistical effect	Negative	Positive
7. Staff acceptability	Acceptable	Doubtful
8. Staff expectations	N/A	Should improve

In summary, the addition of the consultant form of membership reduces the number of voting members on a given committee, thereby (as noted earlier[7]) improving membership interaction. Some staff members may feel threatened if the consultant form of membership is seen as a reduction in status. However, since the consultants would only rarely attend meetings, their productive time would increase proportionately.

The statistical effect of membership/committee reduction is immediately obvious by comparing the matrices of the present system (Table 1) with the proposed system (Table 10). Table 11 summarizes this comparison (consultants are not included in Table 11 because of their relative lack of committee involvement).

TABLE 11

CURRENT SYSTEM VS PROPOSED COMMITTEE SYSTEM

Statistic	Current	Proposed
Number of committees	30	26*
Average membership	11.3	9.8
Standard deviation	5.1	4.86
Membership range	25	25
Midpoint of range	10/11	9
Membership responsibilities of the top nineteen most "committeed" staff members.		
Average number of committees per member	9.84	6.68
Standard deviation	3.81	3.79
Range of committee responsibilities	10	10
Midpoint of range	10	6

*Departmental conferences not included since their membership is at the discretion of the department chief.

Establishment of the coordinator.--One of the significant problems with the current system noted earlier realted to committee management: No agendas, lack of member preparation, and poor performance on the part of the committee chairmen. Since the chairmen are normally high-ranking staff members whose schedules are very busy, they often do not have sufficient time for adequate meeting preparation. What is proposed is that one of the members be given the position of committee coordinator. The coordinator would prepare agendas, notify members of the meeting date and time, insure reports are ready for committee review. Most committees already have someone who would ideally fit into this role, e.g., the Safety Officer who sits on the

Safety Committee, or the Infection Control Nurse who sits on the Infection Control Committee. Table 12 compares the current system (where the chairman or recording secretary performs coordination) with the results that are possible through establishment of the coordinator position.

TABLE 12

COORDINATING FUNCTION

Criteria	Present	Proposed
1. Authorized by regulation	N/A	N/A
2. Effect on meeting process	Negative	Positive
3. Productivity effect*	Negative	Positive
4. Individual committee burden	N/A	N/A
5. System manageability effect	Negative	Positive
6. Statistical effect	Negative	Positive
7. Staff acceptability	N/A	N/A
8. Staff expectations**	Negative	Positive

*The premise is that more efficient meetings take less time, allowing staff members more time for their jobs.

**The premise is that the coordinator will provide better committee communication, thus members come to meetings better prepared and have a better understanding of the effect of committee deliberations.

Standardization of meeting schedules.--No one would have objection to the establishment of a permanent date/time for the meeting of each committee every month/quarter. Staff members could thereby plan their schedules as far in advance as practical, and conflicts between committee meeting schedules could be avoided. The real issue is the time of day for committee meetings. Three times will be compared to the change criteria: 1100-1230; 1300-1430; and 1500-1630. (A time

period of one and one-half hours was chosen since, as noted earlier, committee sampling revealed that mean committee length was fifty-five minutes with a standard deviation of 21.2 minutes, meaning that about 93 percent of all committees will be less than ninety minutes in length). Table 13 compares the time alternatives to the criteria for a system change.

TABLE 13

EVALUATION OF MEETING TIMES

	1100-1230	1300-1430	1500-1630
1. Regulatory requirements	N/A	N/A	N/A
2. Effect on meeting process	Some*	None	Some**
3. Productivity effect	Some	Great hinderance	Some
4. Individual committee burden	N/A	N/A	N/A
5. Effect on system manageability	Hinderance*	N/A	N/A
6. Statistical effect***	Negative	Negative	Positive
7. Staff acceptability	Unacceptable	Acceptable	Some non-acceptance
8. Staff expectations	N/A	N/A	N/A

*Time period coincides with lunch hour. Therefore provision would have to be made for dining while meeting, a situation for which there are no facilities at Darnall Army Hospital.

**It is assumed that meetings scheduled on the last hour of the day will encourage efficiency.

***Meeting over the lunch hour will encourage absenteeism. Adding a peak patient period (1300-1430) will either increase absenteeism or affect productivity.

The time period that meets most criteria is 1500-1630. This period comes after the majority of outpatient and administrative workload has been accomplished. Coming at the end of the day, this

period provides incentive for making efficient use of committee time. Unfortunately, there is a conflict with the daily change in nursing shifts. This would result in a conflict for one or two nursing personnel about eight times per month. The alternative is to hold meetings at 1300, but this is a peak outpatient period, conflicts with operating room schedules, and current experience shows that when a staff member has a 1300 meeting, the 1230-1300 time frame is fairly unproductive. Therefore, it appears that the 1500-1630 time is the optimal feasible period.

Summary

Current shortcomings

Review of the current committee system reveals that hospital committees: (1) are considered to have internal management problems affecting efficiency and effectiveness; (2) while generally meeting requirements, they fail to do so in the areas of utilization review and special care; (3) are generally too large for effective intra-committee working relationships; and (4) could be better systems managed through changes to the hospital committee regulation.

Improving the current system

While the current committee system needs improvement, it is not without value and utility. Therefore changes are directed at improving the current system rather than development of an entirely new one.

Changes for improvement include: (1) addition of committees to meet requirements, combining committees where appropriate, and

eliminating those committees that are neither required nor serve a valid purpose; (2) reduction of membership size by either elimination of members or reducing some members to the status of non-voting consultant; (3) establishment of the position of coordinator in all committees to manage committee affairs; and (standardization of committee meeting schedules.

FOOTNOTES

[1]Headquarters, US Army MEDDAC Fort Ord, MR15-1: Committees, Boards, Conferences, and Councils (Fort Ord, California:MEDDAC, August 11, 1978).

[2]Headquarters, US Army MEDDAC Fort Jackson, MR 15-1: MEDDAC Committees, Boards, Conferences, and Councils (Fort Jackson, S.C.: MEDDAC, January 12, 1979).

[3]Headquarters, US Army MEDDAC Fort Bragg, SOP Number 1-11: Committees, Boards, Conferences, and Councils (Fort Bragg, N.C.: MEDDAC, December 13, 1976)

[4]Joint Commission on Accreditation of Hospitals (JCAH), Accreditation Manual for Hospitals (Chicago: JCAH, 1978), p. 174.

[5]Ibid., p. 145.

[6]Headquarters, Health Services Command (HSC), Pamphlet 40-1; Committees, Boards, and Functions (Fort Sam Houston, Texas: HSC, January 1979), p.2-1.

[7]Filley, p. 14.

[8]Loc cit.

III. CONCLUSION

Implementation

New hospital regulation

The changes to the present system are adopted in draft Regulation 40-20 (Appendix E contains the first nine pages). The alternatives to problems previously identified have been adopted in the regulation as follows.

Coverage of requirements.--Utilization Review and Special Care Units have been added to the committee system. Enlisted Education Advisory Board and Dental Education Committee have been eliminated as standing committees. Energy Conservation functions have been included in the Safety Committee; Community Health Education Committee functions have been included in the Ambulatory Patient Care Committee; and Linen Control functions have been included in the Minor Construction Committee.

Committee management.--Agendas are now required by all committees and will be circulated far enough in advance to enable adequate membership preparation. The duties of committee coordinator are defined and a coordinator has been designated in every committee. Minutes reflect actions pending, members responsible for the actions and suspense dates for action completion.

Membership.--Those changes noted on the membership matrix (Table 9) have been incorporated, reflecting the philosophy that members should (1) hold organizational positions of significant continuing, and routine importance to the committee, and (2) possess expertise of sufficient depth and breadth so as to qualify the member to vote on all matters coming before the committee.

Shortcomings of the current committee memorandum.--Regulation 40-20 establishes a hierarchy of committees to insure adequate professional review and coordination of committee actions. Also included is a master schedule of all standing committee meetings. Starting times are 1500 or later unless the particular committee has provided sufficient justification for an earlier time. Additionally, each committee annex reflects the authority of that committee to initiate action affecting the organization. References for each committee have been updated to reflect current documents. The functions of each committee are now sufficiently detailed so that a new member could gain significant insight into the committee's role within the hospital.

Facilitating change

In order to gain staff acceptance (one of the original constraints), it will be necessary to insure that committee officers and general membership are briefed on the findings of this study and are given the opportunity to comment on the draft regulation.

Final review of draft regulation.--To date, the membership of all committees has been given draft copies of the specific annex to

draft Regulation 40-20 pertaining to their committees, and encouraged to offer suggestions. These suggestions have been incorporated into the final draft. Now the membership should be given the opportunity to review the entire regulation. Where conflicts continue to exist between the membership and the project officer, those concerned need additional opportunity to address their points of view before the commander makes a final decision.

Briefings on the new system.--The chairmen, coordinators, and recorders of all committees need to be briefed on the results of the committee research and the functioning of the new system. As a result, chairmen should have a better awareness of their own shortcomings and provide the membership with the kind of leadership shown to be lacking by the questionnaire survey, and by observation of a sampling of committee meetings.

Instruction in "chairmanship"

Either the hospital's Organizational Effectiveness Officer or the Committee Project Officer should provide instruction to committee chairmen concerning effective management of the meeting process. This can be done in one of two ways, either formal instruction and/or feedback on observation of specific meetings. As noted earlier, most authorities on the committee process identify the chairman as the most important element in developing an effectively functioning committee.

Followup

In order to insure that (1) the new system is, in fact, effective, and (2) changes are successfully implemented, sufficient followup is required.

Continuous monitoring.--Presently, there is no single individual who looks at the overall committee process on a continuous basis. Minutes need to be checked against the regulation to insure that all functions are being addressed. Such an activity would appear to be best handled by the administrative resident. For not only is he the only member of the organization with enough time to monitor the entire committee system, but also he is charged with attendance at all committee meetings. Additionally, the monitoring of the committee system would appear to be an excellent learning experience.

Standards for evaluation.--In addition to system monitoring, there are significant quantitative standards by which the revised committee system can be compared to the old system. These include:

--Resurvey . The questionnaire can be resurveyed and the results compared to the original survey.

--Statistical sampling. Such factors as length of meetings, percent attendance, delay in meeting starting time can be sampled and compared to the original data discussed previously. While such factors themselves may not reveal specific weakness in the revised system, they are one indicator of system efficiency.

--Annual General Inspection results. Fiscal year 1980 results can be compared with those of fiscal year 1979.

Recommendations

For successful implementation of the changes required to improve the committee system at U.S. Darnall Army Hospital, it is recommended that:

Approval of Draft Regulation 40-20

After sufficient staffing and coordinating, Draft Regulation 40-20 (Committees, Boards, Conferences, and Councils) should be implemented not later than June 1, 1979.

Staff information briefings

A series of information briefings should be scheduled for committee chairmen, recorders, and coordinators. Due to the somewhat sensitive criticism of chairmen resulting from this study, it is recommended that they be briefed separately. Briefings should commence not later than May 15, 1979, and be completed prior to implementation of the revised system.

System monitoring

The administrative resident should be given the additional duty of monitoring all committee activity for compliance with the new regulation.

Resurvey and resampling

During January 1980, recommend that the administrative resident

resurvey committee members and resample committees for the statistical data previously discussed. This data may then be used to revise the committee system as appropriate.

APPENDIX A

Definitions

APPENDIX A

Definitions

Annual General Inspection. A command inspection initiated by an organization of its subordinate units. The purpose is to evaluate compliance with regulation, assess the state of mission readiness, unit morale, and discipline. Every unit in the Army receives this inspection annually.

Army Medical Department (AMEDD). That grouping of officer, warrant officer, and enlisted personnel with medically related specialties, medical units, and medical staff agencies that fulfill the medical mission and act out the medical roles of the Department of the Army.

Chief, Professional Services. The equivalent of the chief of medical staff of a civilian hospital.

Executive Officer. The equivalent of the associate executive director in a civilian hospital.

Headquaters, Health Services Command (HSC). The principal command and control unit for all AMEDD activities, personnel, and units that are located within the United States, but are not assigned to United States Army Forces Command

Hospital Commander. The equivalent of the executive director in a civilian hospital.

U.S. Army Medical Department Activity (USA MEDDAC). Those medical activities that are assigned to HSC and provide the primary source of medical support for Army posts, camps, and stations within the United States.

APPENDIX B

Required Committees

APPENDIX B

Required Committees

Defined by HSC Pamphlet 40-1

Required under specific title

Ambulatory Patient Care Committee.--Primary function is to provide the hospital commander with an assessment of ambulatory patient care delivery.

Child Protection and Case Management Team.--Provides evaluation, diagnosis, treatment, and recommendations of disposition of children who are abused or neglected.

Credentials Committee.--Recommends to the hospital commander initial clinical privileges, annual review, and alteration as circumstances indicate.

Education Committee.--Provides general supervision of all graduate medical and continuing medical education programs.

Executive Committee.--Provides final review and approval of all activities involving the hospital committee system.

Health Consumer Committee.--Serves as a communication forum between health care providers and supported population.

Infection Control Committee.--Reviews, establishes, and monitors policies relating to nosocomial infection, occupational health, and antibiotic usage.

Medical Library Committee.--Approves acquisition of new medical books and periodicals, establishes library usage policy, and determines disposition of library holdings.

Medical Care Evaluation Committee.--Performs medical audits and utilization review.

Nursing Audit Committee.--To conduct retrospective and process audits necessary for satisfactory evaluation of the quality of nursing care, as part of the overall medical care evaluation process.

Program Budget Advisory Committee.--Provides financial review, analysis, and planning.

Rabies Advisory Board.--To provide review of treatment procedures for rabies treatment, and consultation on specific cases.

Safety Committee.--Implements and monitors a comprehensive, hospital-wide safety program designed to reduce or eliminate potential safety hazards to patients, staff, and visitors.

Therapeutic Agents Board.--Recommends evaluation, selection, procurement, and distribution of drugs, as well as the policies and practices related thereto.

Functions not requiring a separate committee

Blood and Tissue Review.--To review the results of surgical procedures and the use of blood in support of surgical procedures.

Community Health Education Program.--To familiarize the supported population with medical treatment facilities organization, policies, schedules, and services.

Departmental Conferences.--Provides a forum for discussing internal policies, procedures, and inservice education.

Emergency Medical Services.--To provide guidance, planning, support, surveillance, and ongoing evaluation of the hospital emergency medical service.

Joint Staff Conference.--Provides a communications forum between the clinical and administrative staffs.

Medical Record Review.--To provide an audit of both inpatient and outpatient records for evaluation of record thoroughness, completeness, and quality of care.

Utilization Review.--Provides quality assurance analysis, cost effectiveness review, and concurrent evaluation of resources management, appropriateness of admission and length of stay.

Required by Other Army Regulations

Energy Conservation Committee

Required by HSC Regulation 11-3. To review practices and recommend policies that will lead to efficient use of energy resources.

Linen Management Committee

Required by HSC Regulation 40-15. Provides review of linen usage rates and recommends policies to reduce loss through pilferage and destruction.

Military and Civilian Awards

Required by Army Regulation 672-20. Provides internal review of award recommendations for assigned civilian and military personnel.

Equal Opportunity Council

Required by Army Regulation 600-21. This council attempts to ascertain the climate of equal opportunity within the organization and makes recommendations, as appropriate, to the commander.

Required by Joint Commission on Accreditation of Hospitals

Special Care Units Committee

Provides a forum for the review of practices and policies related to the conduct of multi-purpose special care treatment units.

APPENDIX C

USDAH Committee Questionnaire

Committee_____

USDAH COMMITTEE QUESTIONNAIRE

Please answer the following as frankly as possible. Combined results will provide data for improvement of the overall committee system at Darnall.

1. Has anyone ever briefed you concerning your duties and responsibilities to this committee? Yes _____ No_____

2. Do you understand the purpose and objectives of this committee? Y____ N_____

3. How often do you read the minutes of this committee?
Never_____ occasionally_____ Usually_____

4. Have you ever read that portion of MEDDAC Memo 40-20 (Committees, Boards, and Conferences) dealing with this committee? Y_____ No_____

5. How well are you prepared to discuss the agenda when you come in and sit down--i.e., do you know ahead of time what will be discussed?
No idea_____ Some idea_____ Good idea_____

6. In your opinion, is this committee well run by the chairman? Y____ N_____

7. Could this committee be combined with another? If so which one?____ _____

8. How much authority does this committee have for its areas of interest?
Little_____ Some_____ Much_____

9. How valuable is this committee in providing guidance for your area of interest at Darnall? Little_____ Some_____ Much_____

10. Compared to other hospitals (or other organizations with which you are familiar), how effective is the committee system at Darnall? Darnall is (worse) (about the same) (more effective) than most others.

11. Generally speaking, do you think that committees can be effective management tools in this hospital? Y_____ N_____

12. Are there any members (duty position-not individuals) who do not need to belong to this committee? If so, which ones?_____

13. What about the number of people on this committee?
Too few_____ About right_____ Too many_____

14. What about the length of the meetings of this committee?
Too short____ About right_____ Too long_____

15. Do you think that a briefing/discussion of the purpose, goals, and meeting mechanics of this committee would be useful? Y_____ N_____

16. In your own words, why do we have committees at Darnall (please give a a straight answer. I want to assess your understanding of committees)?

APPENDIX D

Internally Generated Committees

APPENDIX D

Internally Generated Committees

Dental Education

This committee has responsibility for review of all dental post graduate education conducted at Fort Hood, and as such, is comparable to the hospital education committee. However, it is no longer required by HSC Pamphlet 40-1, and is really a function of the post Dental Activity commander, rather than the hospital commander.

Disaster Committee

Although not required by committee, JCAH does require internal and external disaster plans that are to receive periodic implementation. The broad range of coordination involved makes this ideally suited for committee action.

Enlisted Education Advisory Board

This committee was established to provide review of enlisted training programs. It has not met in nine months, and its functions have been incorporated elsewhere.

Hospital Construction

On April 3, 1979, construction commenced on a $48 million expansion and renovation project that will double the usable hospital floor space and completely revise the current working areas of all hospital activities. Therefore a coordinating committee for construction seems appropriate.

Junior Enlisted Advisory Board

This committee attempts to monitor the attitude "pulse" of junior enlisted staff members. The committee is made up entirely of junior personnel and its recommendations go to the commander. There is no way of combining this most useful committee with another.

Junior Program Budget Advisory Committee (Junior PBAC)

The Junior PBAC was organized in order to allow for adequate discussion of the equipment and monetary needs of the various clinical activities. Experience showed that the PBAC was so large and its agenda so full, that such discussion was stifled. This most useful committee allows for comprehensive financial planning of clinical activities which are then integrated with other activities when the PBAC meets.

Minor Construction Review Board

This committee has proved very effective in reviewing requests for minor construction work within the various staff departments and divisions. Such requests have proven quite costly and can accumulate very quickly unless a knowledgeable inhouse group can critically examine the stated justification for such construction work.

Rape Crisis Council

This is a multidisciplinary clinical committee that provides therapy for rape victims. The committee has proven quite effective, and its members wish it to continue functioning.

APPENDIX E

Draft Regulation 40-20
(Basic Regulation With Appendix A-1)

1. PURPOSE. This regulation governs all standing committees, boards, conferences, and councils within USA MEDDAC, Fort Hood, Texas. Included are the committees required by the Joint Commission on Accreditation of Hospitals (JCAH), Army Regulations, and higher headquarters.

2. COMPOSITION. Committee membership is designated by duty position. The Adjutant, US Darnall Army Hospital (USDAH) will provide each committee member with a copy of this regulation in order for the member to become familiar with his responsibilities. Committee membership is classified as regular or consultant. Regular members (or designees) are required to attend all committee meetings. Consultant members attend only at the specific request of the chairman.

3. RESPONSIBILITIES.

a. Committee chairmen will:

(1) Become familiar with the contents of this regulation.

(2) Insure that an agenda is prepared and distributed NLT three working days prior to the committee meeting.

(3) Convene and conduct meetings.

(4) Seek the advice of the Organizational Effectiveness Officer, as appropriate, in order to become more effective in the conduct of meetings.

(5) Review and question incidences of chronic absenteeism.

(6) Insure that reports, both oral and written, are complete prior to the meeting at which they are to be presented.

(7) Insure the presence of persons scheduled to provide information or advice.

b. Regular members will:

(1) Become familiar with the functions of the committee.

(2) Actively participate in committee meetings.

(3) Attend all meetings or insure a substitute attends.

(4) Prepare for meetings by reviewing the previous minutes and agenda.

c. Consultant members will:

(1) Be familiar with the functions of the committee.

(2) Attend meetings when required by the chairman.

(3) Be prepared to actively participate and facilitate committee business when in attendance.

d. Committee coordinators will:

(1) Become familiar with the general content of this regulation and the specific issues relating to each committee.

(2) Assume duties delegated by the chairman, such as: agenda preparation; preparation of reports for meetings; followup actions, to include actions pending; insuring attendance of members; and, insuring the chairman is briefed and prepared to conduct the meeting.

(3) Inform new members of their duties and responsibilities.

e. The committee will:

(1) Develop an annual program which states the objectives and goals of the committee. The committee will review and update the program annually during the second calendar quarter.

(2) Forward two copies of annual programs and program reviews to the Executive Committee for approval.

f. The recorder is responsible for the preparation, editing, and distribution of the minutes as outlined in paragraph 4b of this regulation.

4. ADMINISTRATIVE DETAILS.

a. Frequency. Frequency of meetings is specified in the appropriate appendix of this regulation and is indicated in Figure 3.

b. Minutes of each meeting will be prepared and signed by the Recorder IAW Figure 1. Minutew will be signed by the Chairman. The recorder will forward the record copy (original) of the minutes within ten working days of the meeting to the Executive Officer for approval of the Commander and file in the Adjutant's office. If minutes are to be reviewed by the Executive Committee, they will be submitted in two copies at least five working days prior to the next Executive Committee meeting. Minutes to be reviewed by a parent committee (i.e., APC, MCEC, etc.) they will be forwarded in sufficient time to be available for that committee's next meeting. (See Figure 2)

c. Distribution. One copy will be made for each member of the committee and distribution made after command approval.

d. The record (original) copy of the minutes will be maintained in accordance with the AR 340-18 series in the office of the Adjutant. The minutes maintained by the Adjutant will be available for review by the JCAH surveyor. If the committee does not meet within the specified time frame, the recorder will prepare an MFR to be placed in the record file.

e. Departmental/divisional committees not defined in this regulation, but required by this and other Army regulations, or deemed necessary by department or service chiefs will:

(1) Record accurate minutes of meetings IAW Figure 1 of this regulation, except an approving authority is not necessary.

(2) Maintain a file of the minutes of the meeting.

(3) Forward an information copy of the minutes to the Chief, Professional Services (professional activities), or the Executive Officer (administrative activities).

5. MISCELLEANOUS.

a. A quorum will consist of a simple majority of regular committee members. Consultant members present may vote only on those issues for which their presence is required.

b. The Administrative resident will monitor committee meetings for compliance with this regulation and provide the Executive Officer/Chief, Professional Services with an informal report when deficiencies are noted.

c. Committees meeting quarterly will meet during the first month of each quarter as indicated in Figure 3. Committees meeting bimonthly will meet on even-numbered months.

d. Changes to committee membership and functions must be submitted through the committee to the Executive Committee, with appropriate written justification.

e. Unless specified otherwise, all committee meetings are considered open to all members of the hospital staff.

f. The following committee functions have been absorbed into other existing committees: Energy Conservation(Safety); Community Health Education Program (Ambulatory Patient Care); and Linen Management (Minor Construction Review Board).

g. The Organizational Effectiveness (OE) Officer will periodically monitor committee meetings and provide the chairman with informal feedback on the effectiveness of the meeting process. Where indicated, the OE Officer will volunteer his services for improvement of committee management skills.

The proponent of this regulation is the Office of the Adjutant.

Users are invited to send comments and suggested improvements to Commander, Medical Department Activity, ATTN: AFZF-H-A, Fort Hood, Texas 76544.

FOR THE COMMANDER

DEPARTMENT OF THE ARMY
MEDICAL DEPARTMENT ACTIVITY
FORT HOOD, TEXAS 76544

OFFICE SYMBOL DATE

SUBJECT: Minutes of (Name of Committee, Board, Conference, or Council)

1. Date and time of meeting (required)

2. Members present: (Name, rank, position)

   Members absent: (List by position)

   Non-members attending: (Name, rank, position)

3. Old business: (This section should include action taken on prior recommendations and/or actions pending relative to business conducted during or since previous meetings. Record must show approval/disapproval of previous meetings.)

4. New business: (Should include as appropriate)

   a. Summation of discussion/presentation.
   b. Results of studies, surveys, etc.
   c. Recommendations.

5. Actions pending: (Cite actions which are required, from previous and/or present meeting, with a designation of who is responsible for the action and time frame for completion).

6. Time of adjournment (required)

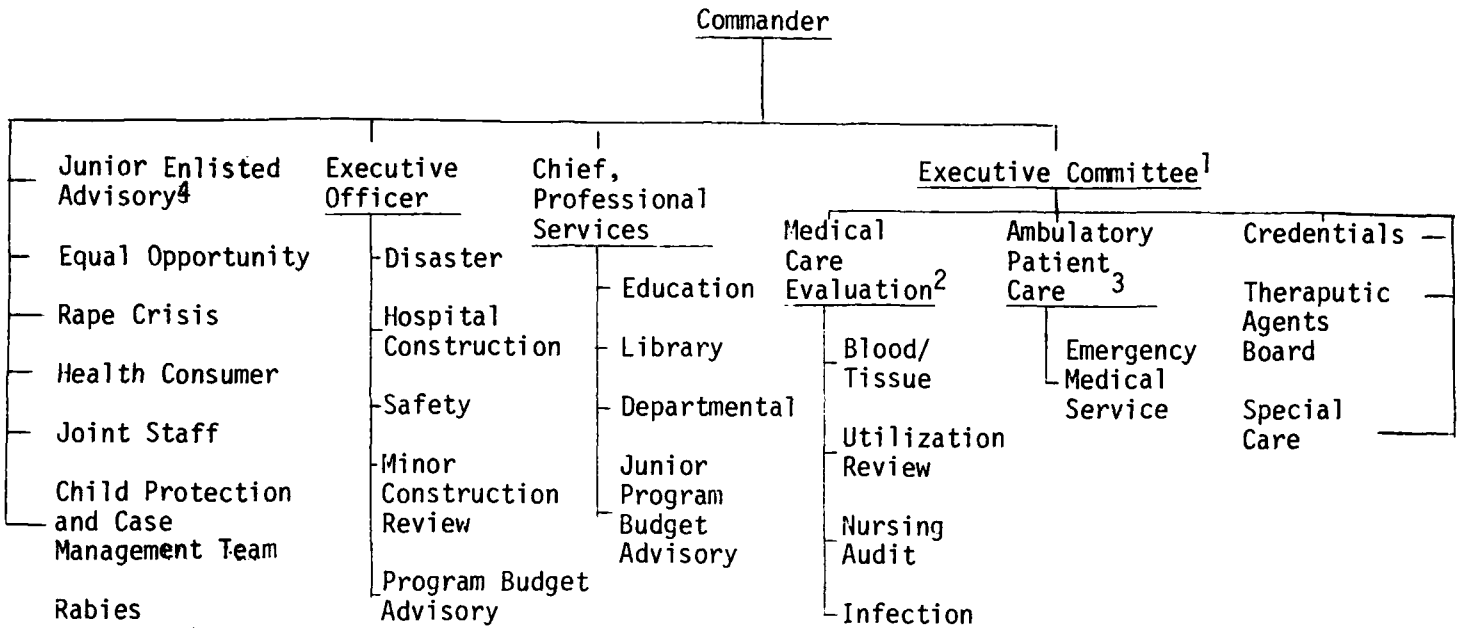
SIGNATURE
(Recorder)

SIGNATURE
Chairman

Approved/Disapproved

SIGNATURE
(Commander's signature block)

Figure 1



Note 1. The Executive Committee reviews the minutes of the Medical Care Evaluation, Ambulatory Patient care, Credentials, Theraputic Agents Board, and Special Care committees, plus any committee minutes reviewed by those committees.

Note 2. The Medical Care Evaluation Committee reviews the minutes of the Blood/Tissue, Utilization Review, Nursing Audit, and Infection committees.

Note 3. The Ambulatory Patient Care Committee reviews the minutes of the Emergency Medical Servic Committee.

Note 4. The Junior Enlisted Advisory Council minutes are reviewed by the Command Sergeant Major

FIGURE 2

Reg 40-20

AMBULATORY PATIENT CARE COMMITTEE

1. Membership is appointed as follows:

C, Professional Services (Chairman)
C, Clinical Support Division (Coordinator)
C, Department of Primary Care and Community Medicine
C, Department of Surgery
C, Department of Medicine
C, Ambulatory Nursing Service
C, Central Appointments
Community Health Nurse
Patient Representative Officer
C, Family Practice
C, Food Service Division
Public Health Dental Hygienist (Consultant)
Deputy for Veterinary Activity (Consultant)
C, Acute Minor Illness Clinic (Consultant)
C, Preventive Medicine Activity (Consultant)
Secretary to the Executive Officer (Recorder) (without vote)

2. Functions:

a. To provide the hospital commander with an assessment of ambulatory patient care within the community.

b. To provide a forum for the presentation and discussion of MEDDAC practices, policies, and programs designed to improve ambulatory patient care within the community.

c. To review and assess all APC Program Progress Reports and other audit and inspection reports related to ambulatory patient care.

d. To evaluate the effectiveness of each APC Program component at least annually, and to amke followup recommendations to the commander.

e. To accomplish the Community Health Education Program objectives ad defined in APC Model #14.

3. Meeting frequency. Quarterly or on the call of the chairman.

4. Authority. The committee serves as the commander's principal advisor on ambulatory patient care, and will be given the opportunity to offer recommendations on all proposed changes to the APC Program.

5. Minutes of the committee meetings will be prepared, approved, distributed, and filed IAW paragraph 4b,c,d of this regulation. This community assumes the functions of the Community Health Education Committee.

6. References. Ambulatory Patient Care Program and Models; HSC Regulation 40-5; and HSC Pamphlet 40-1.

COMMITTEE SCHEDULE

US DARNALL ARMY HOSPITAL

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
FIRST[1]	1530 Blood/Tissue	1530 EMS	1300 Special Care (even months)	1300 Nursing Audit 1530 Utilization	0800 Executive 1530 TAB
SECOND	1530 Infection	1300 CPCMT 1530 Credentials	1530 Education	1530 APC	1530 Joint Staff
THIRD	1530 Jr Enlisted Advisory	1300 Rape Crisis 1530 Disaster	1530 Library	1300 Equal Opportunity	1530 Safety
FOURTH		1300 CPCMT 1530 MCEC	1530 Minor Construction	1300 Health Consumer	1530 Joint Staff

Note 1. The date for a particular meeting is to be read as, "the first (second, etc) Monday (Tuesday, etc) of the month or quarter as applicable."

Note 2. Meetings that are scheduled on the call of the chairman: Jr. PBAC, PBAC, Departmental Staff, Rabies, and Hospital Construction.

Note 3. The hospital conference room is automatically reserved by the Adjutant for those meetings on the dates specified.

FIGURE 3

COMMITTEE SCHEDULE

US DARNALL ARMY HOSPITAL

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
FIRST[1]	1530 Blood/Tissue	1530 EMS	1300 Special Care (even months)	1300 Nursing Audit 1530 Utilization	0800 Executive 1530 TAB
SECOND	1530 Infection	1300 CPCMT 1530 Credentials	1530 Education	1530 APC	1530 Joint Staff
THIRD	1530 Jr Enlisted Advisory	1300 Rape Crisis 1530 Disaster	1530 Library	1300 Equal Opportunity	1530 Safety
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Note 1. The date for a particular meeting is to be read as, "the first (second, etc) Monday (Tuesday, etc) of the month or quarter as applicable."

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FIGURE 3

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